

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155784</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/06/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1420 E DOUGLAS RD</b> <b>MISHAWAKA, IN 46545</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00188300, IN00188491, IN00189495 and IN00189717.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00184037.</p> <p>Complaint IN00188300 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00188491 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00189495 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00189717 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 4 - 6, 2016</p> <p>Facility number: 012329 Provider number: 155784 AIM number: 201002500</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 17 Medicaid: 46 Other: 28 Total: 91</p> <p>Sample: 6</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1  Creekside Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00188300, IN00188491, IN00189495 and IN00189717.  Quality Review completed by 14454 on January 8, 2016.	F 000			